STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	02/23/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE ON EASTERN	105 EASTERN AVENUE BELLWOOD, IL 60104

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W 488	Continued From page 84 mashed potatoes, banana and chopped barbecued riblets independently. R9's Dietary Comprehensive Assessment dated 12/2/08 includes under feeding status, "Feed self with set up and verbal prompting." R15's Dietary Comprehensive Assessment dated 1/2/09 includes under feeding status, "Feed self with set up." R16's Dietary Comprehensive Assessment dated 6/3/08 includes under feeding status, "Feeds self with set up." R17's Speech Pathology consult dated 11/25/08 includes under strengths, "R17 is verbal and will request preferences. She can be conditioned to feed herself but needs cues to reduce rate and amount of intake as well as to prevent stealing food from others during meals." R18's Dietary Comprehensive Assessment dated 8/5/08 includes, "Feed self with set up." R19's Occupational Therapy Assessment dated 6/2008 includes under service objectives , "Encourage independent feeding." Under feeding, it includes, "spillage noted, plate guard added, independent/ set up." R20's Dietary Comprehensive Assessment dated 2/26/08 includes under feeding status, "Feeds self with set up." E24, Direct Care Staff, was interviewed on 2/3/09, at 5:30pm. E24 stated, "R16 and R18 probably will be able to serve themselves but it depends on the day. While R9, R15, R17, R19	W 488		

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W 488	Continued From page 85 and R20 might be able to serve themselves with hand over hand assistance - but you have to be there with them."	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1210d) 350.1230b)3)6)7) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: d) Physical and occupational therapy services for purposes of initiating, monitoring and follow-up of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist.	W9999		

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W9999	Continued From page 86 Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to implement their policy to prevent neglect, when they failed to ensure the safety of 1 of 1 client in the sample (R8) with a history of 23 falls in 11 months. Findings include: 1) The facility's policy titled, "Abuse and Neglect of Persons Receiving Services #136" revised 1/29/07, includes the following, "Neglect: The failure to provide adequate medical, personal	W9999		

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W9999	Continued From page 87 care or maintenance, which failure results in physical or mental injury to an individual..." According to the Individual Program Plan (IPP), dated 2/25/08; R8 is 61 years old and has diagnoses which include Profound Mental Retardation, Cerebral Palsy and Spastic Paraplegia. She is non-verbal and ambulates with a walker. R8's IPP / Mobility / Motor Skills identifies her as having some difficulty accessing uneven surfaces due to her unstable gait and falling due to walking too fast or being startled. The IPP stated that R8 should be supervised at all times while she is using her walker in order to prevent falls. R8's clinical/medical record contained documentation that R8 had 5 teeth extracted due to trauma after a fall on 8/19/07. E1, Administrator, was interviewed on 2/6/09, at 12:30 PM. She confirmed the note and stated that R8 had fallen on 8/19/07 while ambulating with her walker, and 911 was called. She said that R8 was taken to the hospital where 5 teeth had to be extracted due to oral trauma from the fall. An incident report, dated 2/11/08, contained documentation that R8 fell, sustaining a laceration to the back of her head. She was sent to the hospital emergency room for evaluation. R8's annual fall assessment, completed by E3 (Health Service Administrator) and dated 3/19/08, stated that R8 had 7 falls within the prior year, with one major injury [8/19/07], and that she was at high risk for falling. The intervention was, "Remind R8 to slow down when walking with walker and to pay attention to avoid obstacles."	W9999		

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W9999	Continued From page 88 A follow up fall assessment, completed by E3 and dated 6/5/08, stated that R8 had 17 falls since 6/07 and that she remained at high risk for falling. The intervention was, "Falls frequently caused by unexpected sounds, voices, touch. Attempt to approach R8 by speaking in softer voice and never touch her from behind. Other falls occur when R8 walks too fast with walker or walker accidentally gets shoved away from her when she pushes it too hard in jerky movements." R8's annual physical therapy evaluation, dated 3/12/08, stated under "History - No developmental history available." The evaluation did not identify R8's history of falls. The "Summary" contained the following; "There have been no gross functional changes...Strength is functional and good +...Standing balance is good...Gait is disturbed, but functional...Overall endurance is good." The recommendations were for exercises and a re-evaluation in 1 year. This was confirmed by E3, Health Service Administrator, during an interview on 2/5/09, at 1:30 PM. R8's Occupational Therapy evaluation, dated 4/08, did not address the falls. A special team meeting (STM) was also held on 6/5/08, for R8's frequent falls. The team consisted of the QMRP, Social Worker, Health Service Administrator and Administration. The teams' recommendations were: weights to be added to R8's walker in an attempt to slow her down, staff to approach her from the front, and to engage her in purposeful activities.	W9999		

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W9999	Continued From page 89 Another STM was held on 11/25/08 for additional falls. The team consisted of the QMRP, Social Worker, Health Service Administrator and Administration. The narrative summary included the following, "...consulting neurologist suggested R8 may have Startle Disease known as Hyperflexia. This is a neurological disorder that can cause an individual to have an excessive startle reaction...This condition is treatable with medication. Doctor has ordered EEG....Pending results, safety measures already in place for R8, will continue." E3 was interviewed on 2/5/09, at 1:30 PM, and stated that the EEG was completed and that R8 is still being worked up for the medical condition, "Startle Syndrome/Disease," which the doctor feels may be the cause of her falls. However, a new treatment/medication has not been started for the Syndrome. According to the facility's fall trending report, R8 had 10 additional falls between the first STM of 6/5/08, when the safety measures were recommended, and the 11/25/08 STM, which recommended continuing the measures already in place. The facility's trending report for R8's falls, from 3/08 to 2/3/09, were reviewed. According to the report and nurses' notes, R8 had 22 falls, 5 with noticeable injuries, while ambulating with her walker. Incident reports and nurses' notes from that time period document that R8 hit her head 5 times after falling; on 6/25/08, 8/19/08, 10/10/08, 10/16/08 and 12/16/08. During an observation on 2/3/08 at approximately 5:00PM, surveyors witnessed R8 fall to the floor while ambulating with her walker.	W9999		

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W9999	Continued From page 90 The record lacked an updated physical or occupational therapy evaluation, and or progress notes, to address the falls. E7, R8's QMRP, was interviewed on 2/5/08, at 12:30 PM. She confirmed that there was not a therapy evaluation addressing the falls. She stated that the team at the STM, not a therapist, had recommended the weights for R8's walker. She stated that the weights were put into place 6/08, but have not worked as planned. E1, Administrator, was interviewed on 2/5/09, at approximately 2:00 PM. E1 confirmed the record findings and stated that additional safety measures, including a change in R8's supervision level while walking, have not been put in place for R8's continued falls. (A)	W9999		